

ANNUAL REPORT CY 2013



"OHA is the best state agency I have ever worked with. Wonderful responsiveness and follow-up"



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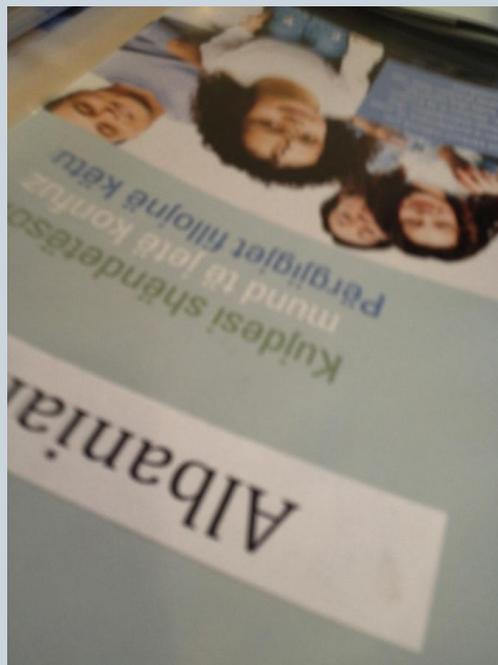
CY 2013

*State of Connecticut
Office of the Healthcare Advocate*

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A Message from the Healthcare Advocate

Welcome to the Office of the Healthcare Advocate's (OHA's) 2013 Annual Report. Our staff continues to provide outstanding service to the residents of Connecticut. As of the date of this report, OHA has saved the consumers of Connecticut over \$60 million since the office opened in 2001. We have worked with tens of thousands of policyholders, patients and families to explain their rights and responsibilities in their health plans, and to advocate for patients when they are denied coverage for treatment or denied reimbursement by their health plans.

In CY 2013, OHA recovered \$9.6 million for Connecticut consumers, taking 12,000 calls on our toll free line and handling 5,683 cases.

OHA has also taken on additional responsibilities for expanding and ensuring access to health coverage for Connecticut residents, recovering state funds, and engaging in systemic healthcare advocacy, all of which we highlight in the report. In sum, in CY 2013, OHA:

- Continued to operate its Consumer Assistance Program (CAP) grant under the Affordable Care Act—541 referrals to our office are the direct result of OHA's CAP status
- Conducted 289 outreach events
- Partnered with Access Health CT to design and implement the Navigator and Assisters Outreach Program, enrolling thousands of residents into healthcare coverage
- Negotiated the behavioral health insurance reform provisions of Public Act 13-3 with the collaboration of representatives of insurance carriers in Connecticut
- Began an evaluation of the Pay-for Performance Strategies under the Connecticut Behavioral Health Partnership in partnership with the Office of the Child Advocate
- Continued to partner with the Department of Children and Families (DCF) to ensure that services for children whose parents have private health coverage are covered under private coverage before the state pays for services
- Continued to collaborate on a project with the Department of Social Services (DSS) to attempt to increase Medicaid recoveries under the Third Party Liability process
- Produced five webcasts on health reform, two television spots and brochures in twenty one languages
- Directed the State Innovation Model Initiative Model Design Grant Process

We strive to empower Connecticut residents to become more informed consumers and effective self-advocates. Our website, Facebook, Twitter and YouTube accounts give timely information about consumer healthcare rights, through webcasts, links to timely news stories and policy developments.

If you have a specific question, or feel you have been incorrectly denied services by your health plan, please contact us by phone at (866) 466-4446 or by email at healthcare.advocate@ct.gov.

Victoria Veltri
State Healthcare Advocate
February 28, 2014

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What OHA Does

“Excellent help - thanks so much! So important to healthcare consumers!!”

Managed Care is a health care system involving the active coordination of, and the arrangement for, the provision of health services and coverage of health benefits. Managed care usually involves three important components: oversight of the medical care provided, contractual relationships and organization of the providers giving care, and the covered benefits.

Managed Care continues to dominate the health care financing and delivery system in the United States. In Connecticut, over 2.5 million health insurance consumers are enrolled in managed care plans. During the past several years, the individual and commercially insured, employer-sponsored segment of the Connecticut population has been joined by many Medicare beneficiaries who have enrolled in managed care plans.

The Office of the Healthcare Advocate helps individual Connecticut consumers enrolled in all types of health coverage, including private and public plans. While the office was created to promote and protect the interests of covered persons under MCO health plans in Connecticut, a major responsibility of the office involves educating consumers about their rights and how to advocate on their own behalf when they have a problem or concern about their healthcare plan. We can answer questions and assist consumers in understanding and exercising their rights to appeal a managed care plan’s denial of a benefit or service.

By law, OHA is authorized to represent Connecticut residents in administrative matters, monitor implementation of state and federal laws, and facilitate comment on those laws.

On the state and national levels, OHA has been very active in promoting healthcare consumer interests in Medicaid and fully-insured and self-insured plans. The Healthcare Advocate is the Vice-Chair of the Access Health CT Board.

OHA pushes for systemic reforms based on sound data and health policy, and as the state’s healthcare watchdog, OHA continues to push for accountability and transparency in healthcare costs, spending and quality of care.

OHA’s focus on implementation and enforcement of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and better access to needed mental health and substance use services for all Connecticut residents, and continues to work with national and state partners on legislative activities, hearings and task force efforts to address long-term remedies that must be implemented.

“Great overall service from OHA-CT from start to finish”

Federal Involvement and Consumer Assistance Program

After passage of the ACA, OHA secured the first of three consumer assistance (CAP) grants from the Department of Health and Human Services' Center for Consumer Information and Insurance Oversight (CCIIO). The grants were the result of a concerted effort by the Connecticut congressional delegation and advocacy organizations to ensure that independent healthcare advocacy agencies like OHA would be adequately funded to assist consumers with healthcare issues.

In 2012, OHA received a Consumer Assistance Program (CAP) grant of \$408,155. This grant followed two previous grants of \$127,967 and \$396,400. The most recent grant expired in December 2013. With our most recent grant, OHA was able to replace three previous grant positions and to make some improvements in its data systems and reporting capabilities.

Under the ACA, all plans, whether self-funded or fully insured, are required to include OHA's contact information on every denial issued, informing consumers that OHA can assist with grievances and appeals. This requirement, in addition to Connecticut's similar law, led to 1136 referrals to OHA in CYs 2012 and 2013.

OHA conducted two television spot campaigns, running spots in English and Spanish throughout the state. The office also produced webinars to assist consumers on health advocacy.

OHA continues to work with partner advocacy organizations and CAP grantees across the country to restore funding to this critical grant program.

"I was greatly impressed by this service and grateful for the compassionate help I received. Much appreciation."



Collaborations

A. OHA and the Navigator and In-Person Assister Program

In 2013, OHA and Access Health CT, Connecticut's Health Insurance Marketplace, rolled out the Navigator and In-Person Assister Program, designed to enroll tens of thousands of individuals into healthcare coverage and to reduce disparities in healthcare coverage and access. The program, initially designed to train 300 community assister organizations and six navigator organizations around the state, has ultimately trained over 800 organizations, including health centers, hospitals and other community organizations committed to helping Connecticut residents get covered. In addition, the training and support infrastructure designed for the NIPA program has continued to evolve in response to feedback from stakeholders and consumers, and will continue to train outreach staff for future enrollment efforts.

The NIPA program accommodates thirty two languages. It provides regular newsletters to participants with timely information on updated enrollment information and materials for assisters and navigators. Because the program is dedicated to consumer engagement and empowerment deep into Connecticut's diverse communities, it allows OHA to reach and assist more consumers than we reached prior to the establishment of the NIPA program.

More information on the NIPA program is available at www.ahctcommunity.org.

B. OHA and the Department of Children and Families

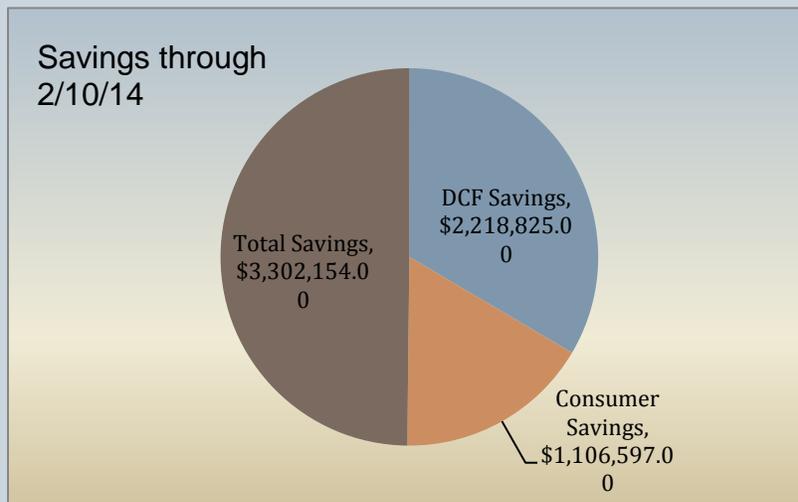
OHA and the Department of Children and Families (DCF) continued a successful collaboration in which families with private healthcare coverage seeking services from the DCF Voluntary Services Program are sent to OHA for assistance.

Under the collaboration, OHA's dedicated staff person:

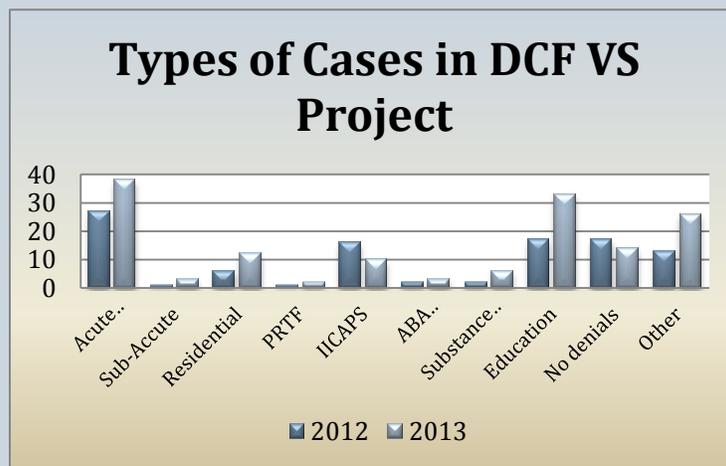
- Counsels families on their rights under the insurance plans, including the right to appeal denials of coverage
- Educates DCF regional office supervisors and workers about the proper use of primary healthcare coverage to prevent unnecessary state spending
- Ensures that planning for children who need out of home placement on a temporary basis is done concurrently by a provider and the Connecticut Behavioral Health Partnership
- Conducts internal and external appeals for medically necessary services for all types of healthcare coverage for referred families

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- Participates in ongoing planning and subsequent appeals for children referred to OHA for a range of services from home-based and outpatient services to acute psychiatric services.
- OHA's collaboration with DCF has saved over \$3.3 million. Over \$2.2 million has been returned to the state while consumers have saved over \$1.1 million. OHA staff handled 223 cases in CY 2013.



Many of the cases OHA handles in this project are for acute levels of care. The project is a win-win in that it avoids cost-shifting of high-cost care to the state and allows OHA to educate Connecticut families about the value of their health coverage.



C. OHA and the Department of Social Services

OHA also collaborates with the Department of Social Services to recover funds for medical services that were paid for by the Medicaid program on services but that should have been covered by private healthcare coverage. An MOU was signed in October 2012 with DSS.

To date, OHA has received over 14,000 claims jointly identified as having recovery potential, and has been working with DSS and its vendor to clarify inconsistencies in the data. Project staff has also worked to identify contacts at the nearly 300 unique insurers with potential liability and develop protocols for confirming and reviewing the claims selected for review. OHA has begun submitting appeals to insurers to recover money for the general fund and has more than \$350,000 in paid and pending recoveries as a direct result of the project.

However, the claims that OHA has received for this project are valued at approximately \$8 million, so as staff continues to resolve systemic issues and reconcile data feeds, and further develops its relationships with the insurers, recoveries are anticipated to increase correspondingly. This is particularly important because DSS estimates that private insurers will deny between \$66 and \$69 million in claims in the next biennium.

Legislative Summary

In 2013, OHA received extensive support to support its mission to assist Connecticut's healthcare consumers.

In 2013, OHA testified on many bills to protect consumers and to improve their chances of prevailing in the appeal process. OHA played a key role in negotiating provisions in P.A. 13-3 related to the establishment of a behavioral health task force and reviews of request for mental health and substance use services in commercial insurance plans. OHA also continued to advocate for legislation to improve transparency in healthcare pricing and quality and testified in support of the use of telemedicine to improve access to care. OHA successfully advocated for a requirement that all employers post OHA's posters in their workplaces to ensure that Connecticut residents can easily access our services. OHA prepared a series of briefings to educate OHA staff and residents on developments at the legislature and to tie OHA's position on proposed legislation to OHA's Principles for Policy Action. (Click on the image below to read our briefings.)

OHA appeared before the following committees during the 2012 legislative session: Insurance and Real Estate, Children's, Appropriations, Public Health and Human Services.

OHA expects to support: a) further initiatives to improve access to mental health and substance use preventive and treatment services, b) initiatives to increase transparency in healthcare costs, pricing and quality and c) efforts to promote alignment toward achieving the triple aim. (See Section on State Innovation Model Initiative.)

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Hospital and Managed Care Community Benefits Report

Connecticut General Statutes § 19a-127k requires hospitals and managed care organizations to report on a biennial basis the community benefits programs they have in place to OHA. In mid 2013, in order to simplify the submission process while also enhancing the level of detail reported, OHA requested that that managed care organizations and hospitals provide their IRS Schedule H Form 990 filings to satisfy this statutory requirement. OHA received one response from an MCO, which reported that it did not have a community benefit program. For 2009, OHA received 24 hospital responses and for 2010, 26 hospital systems provided the requested information.

Every reporting hospital has existing Community Benefit Programs with written policies available for review by the community. Many hospitals also reported active collaboration with community stakeholders, local government agencies and neighboring hospitals to identify common goals and effective means of addressing the needs of the consumers served. Community Health Improvements and Community Building Activities, which included neighborhood revitalization efforts, prescription assistance programs, workforce development, community educational and training events, and more.

Data from the hospital reports is available upon request at healthcare.advocate@ct.gov.

Consumer Feedback:

“Grateful for your compassion at a difficult health juncture in my life. The agency's assistance helped rid the stress that can be debilitating in a crisis.”

“I appreciated the expertise, perseverance & dedication of this office.”

“Your office serves a valuable need for the community. I praise you for your fine services.”

“Exceptional assistance during very trying period.”

“OHA was very helpful & kind. Great agency.”

“Thank your agency for all the good help they gave me.”

Consumer Relations

The number of cases referred from legislators has steadily increased. We continue to encourage legislators and agencies to refer cases directly to OHA for high-quality real time services. OHA experienced another increase over CY 2012 levels in the number of referrals from consumers and providers we've helped in the past. Legislators, providers and consumers know that OHA operates in real time and via direct contact with consumers on: educational cases, medical and behavioral health issues and legal matters. Consumers are very satisfied with our services.

Though denials of services or treatment remains the highest category of complaints OHA receives, the number of cases involving education and counseling increased rapidly because of health reform activities. Mental health continues to be the biggest category of cases OHA handles; one insurer accounts for a disproportionate number of denials and appeals. Fortunately, OHA's advocacy resulted in reversals of denials of treatment or services that involve consumers needing treatment for serious, debilitating, or life-threatening illnesses.

In 2013, OHA fielded 12,000 calls on its toll free line from January through September 2013 and hundreds of calls directly to staff.

OHA's advocacy returned \$9.6 million to the residents of Connecticut in 2013.

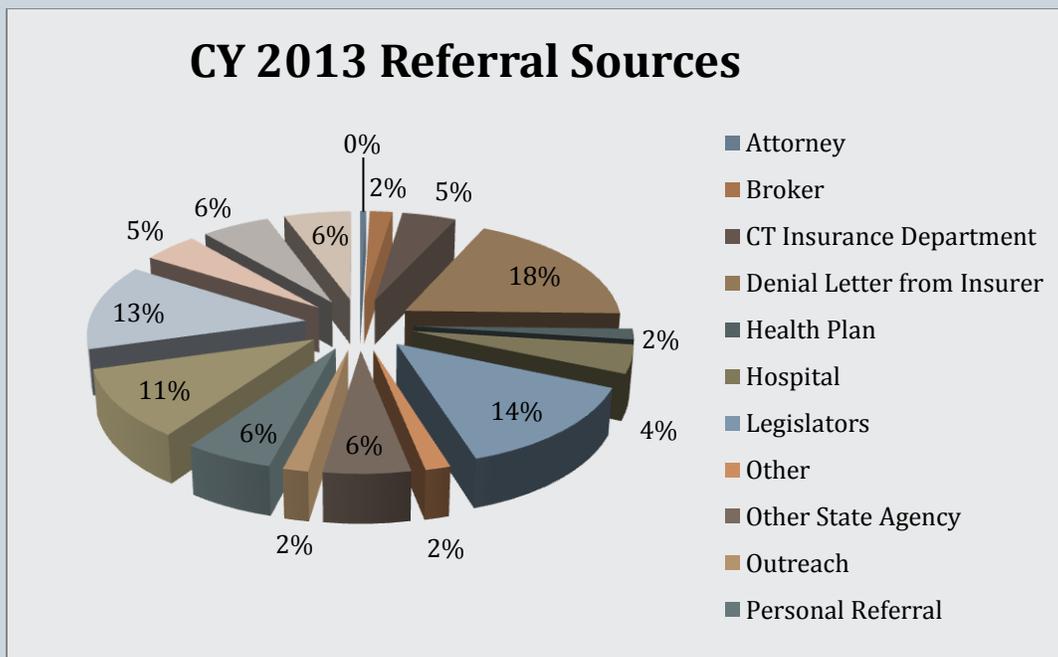


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OHA's consumers continue to give OHA very high ratings. There continues to be very high percentage of customers who would refer someone to OHA. OHA considers this measure the most important measure of OHA's services. The percentage of individuals reporting that they would refer a friend or family member to OHA increased from 87.9 in CY 2012 to 92.1 in CY 2013.

Cases continue to arrive to OHA from a variety of referral sources.



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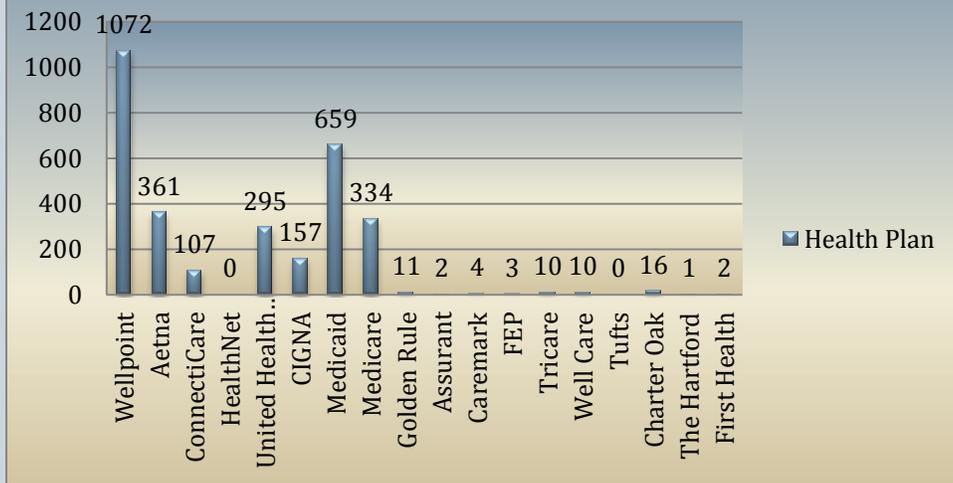
OHA Cases by Highest Frequency of Clinical Category and Calendar Year

Clinical Category (Highest Frequency)	2008	2009	2010	2011	2012	2013	Total
Mental Health/Substance Use *	185	207	264	407	524	435	2022
Medical	123	193	155	257	261	197	1186
Pediatrics	46	65	58	87	93	86	435
Geriatric	41	63	40	58	24	58	284
Pharmacy	68	118	120	173	141	221	841
Surgery	66	107	76	140	151	215	755
Orthopedic	33	81	79	122	113	119	547
Oncology	74	89	50	80	90	143	526
Dental	84	87	56	385	267	320	1199
Physical Therapy	42	39	53	155	110	43	442
OB/GYN	33	49	39	70	33	47	271

* In calendar year 2013, substance use and mental health were tracked separately, and co-occurring conditions were tracked by primary diagnosis.

OHA opened 5,683 cases in CY 2013. OHA closed 3597 cases in 2013. Additional cases to be closed lagged beyond December 31, 2013, because of the substantial incoming case volume for coaching cases in the fourth quarter concerning requests for assistance with HUSKY and Access Health CT enrollment.

Cases by Carrier CY 2013



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Consumer Stories

Madison is a fifteen year old adolescent who was referred several times over a four year period to residential care in CT but was denied based on the fact that her primary health carrier excluded the facility her provider recommended under her health plan. The company agreed initially she required the residential level of care but only had one in network facility in Connecticut. The other facilities in her plan were out of state. Because of Madison's acuity, severity of depression, nine suicide attempts, and drug resistant medication trials, the in state, in network facility declined her referral. However, the component of intensive family therapy that Madison needed was available at the Solnit Center.

The Office of Health Care Advocate advocated that Madison should receive her medically necessary residential treatment at Solnit Center based on her history of recent and multiple hospitalizations and recommendations by her outpatient and inpatient providers. OHA worked closely with the family, outpatient providers and the Department of Children and Families to secure placement at the Solnit Center and received partial reimbursement in the amount of \$131,976 from the insurance carrier for Madison's treatment

OHA argued that since the carrier did not have an adequate facility in its network available in state to provide the appropriate care, the carrier was required to pay for Madison's care at Solnit Center, an out-of-network facility, at an in-network rate. Madison's psychiatric treatment assisted her in maintaining her overall health. She is now thriving in the community, attends school regularly, has strengthened family and friend connections, and plans to pursue college.

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Robert and Royce Carter of Woodstock CT received assistance from the OHA this year and they say that “would not have been able to navigate their way through the predicament to a successful outcome without the help they received from the OHA.” Mrs. Carter received medically necessary services at the UMASS Memorial Medical Group, Inc. that was originally denied by her insurance company. She was notified of this denial of payment via an Explanation of Benefits (EOB), which stated the amount that wasn’t paid and because of federal law, included information about her appeal rights and provided the OHA contact information for any assistance needed in understanding those rights. An OHA nurse consultant assigned provided the Carters with a copy of the Medicare Appeals Booklet and assisted them with preparing an appeal letter. In this case, a ‘good cause extension’ was required from Medicare in order to initiate an appeal because the allowed amount of time to appeal had past. As a result of the assistance the Carters received from the OHA, and the action they took to self-advocate and initiate an appeal, the filing extension was granted and the first level medical appeal was convened. The appeal resulted in the denial of coverage being completely overturned relieving the Carters of responsibility for paying the \$1946.17 bill.

Sandra Apuzzo The next case demonstrates one of the positive impacts of the Affordable Healthcare Act, specific to the expanded coverage for preventive services for women that went into effect on January 1, 2013. Mrs. Sandra Apuzzo contacted our office immediate upon receipt of surgical bills totaling \$21,389.00 and her Estimation of Benefits (EOB) that stated her permanent surgical contraception had been denied on the basis of it being an exclusion or limitation of her Plan. The nurse consultant assigned to in this case immediately recognized that the health plan denied this claim as an administrative error and offered to intervene directly on Mrs. Apuzzo’s behalf. OHA recognized that the Plan had not taken the expanded prevention coverage service for women into account when it processed the claim for surgical services. Once the OHA pointed out this error and provided the health plan with a copy of its own PPO Amendatory Rider that verified the services in question should have been covered at 100%, the Plan acknowledged the mistake, took corrective action, and reprocessed the claim in the consumer’s favor.



S. B. is a teenager who was denied a tonsillectomy for tonsil stones that had affected her most of her life. The insurance carrier stated that the consumer did not meet the policy criteria and that the surgery was not medically necessary. OHA assisted the consumer by collecting medical data, clinical study reviews and personal and professional letters for the appeal. As the second appeal was submitted for presentation, the carrier had a physician of like specialty review the case again. After reviewing the appeal in-depth, the physician concurred that the tonsillectomy was justified and should be covered. The following month S.B. had her tonsillectomy. Her mother stated, “[T]he surgery went well and she is on the road to recovery. Thank you again for all your help with this process.”

M.A. had a gastric-bypass that helped her lose a significant amount of weight. She started to have extreme neck and back pain after losing that weight. After many types of therapies, medications and special garments, the pain did not subside and interfered with M.A.’s activities of daily living and social activities. Her doctor informed her that she would need to have a breast reduction in order to relieve the pain. After considerable review of this surgery and with the support of her physician, she decided to go ahead and have the surgery. Her health plan denied the surgery as not “medically necessary”. M.A., with the assistance of her medical team, contacted OHA for help. A comprehensive appeal package was put together and submitted to the insurance carrier. The denial was overturned and M.A. proceeded with her surgery. M.A. sent a letter thanking OHA with a quote from Vince Lombardi that “there is only one way to succeed in anything, and that’s to give it everything.”

Consumer A required specialized radiation therapy to her brain, as recommended by several consultants in Boston and Cleveland. The providers at the hospitals



**OHA Webinars on
YouTube at [StateofCTOHA:](#)**

Affordable Care Act Intro

**What is the Healthcare
Exchange?**

**Health Insurance Problems in
Connecticut**

**Terms, Definitions & Facts
About Insurance**

Why is Insurance Important?

How Can OHA Help You?



OHA is on Facebook



OHA on Twitter

@State_of_CT_OHA

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tried to appeal the denials of coverage for the radiation therapy, but lost. The consumer called OHA for assistance after seeing OHA's contact information on a denial letter. OHA reached out to the human resources department at the consumer's employer requesting that the employer consider the consumer's appeal of the denial by the third-party administrator. An OHA nurse consultant prepared the appeal gathering additional research articles in support of the specialized radiation therapy. The review board approved the exception to the medical policy and the consumer was able to start the therapy.

In 2011, **Consumer B**, gave birth to premature twins that were three months early. The mother had insurance through her employer and the father had health coverage through his employer. The parents were not on each other's plans. All of the medical bills for the hospital stays were paid by the mother's health plan. Nearly two years after the twins' birth, the mother received notification that the payments from the twins' birth were retracted because of the birthday rule. The family contacted Office of the Healthcare Advocate for help.

Most health plans apply the birthday rule; if both parents have healthcare coverage through their employers, the parent whose birthday comes first in the calendar year is the parent who has to put the children on their policy. In this case the mother put her children on her policy without knowing the birthday rule and her birthday came after her husband's. The health plan denied coverage on the basis that the children should have been covered by the father's policy. The mother was not educated by her health plan about this rule when the twins were initially signed up. After working with both health plans, OHA was able to reverse the denial by the mother's plan. The mother's plan agreed to pay the bills in full from the birth of the twins. An astronomical bill such as this, \$2.4 million, would have changed the family's life forever.

"This agency is the most professional & most willing to help agency I have ever had the pleasure of working with. I have recommended OHA to many people."

Advocacy for Individuals with Mental Health and/or Substance Use Services Needs

Under Conn.Gen.Stat. § 38a-1041(e) shall, "establish a process to provide ongoing communication among mental health care providers, patients, state-wide and regional business organizations, managed care companies and other health insurers to assure: (1) Best practices in mental health treatment and recovery; (2) compliance with the provisions of sections 38a-476a, 38a-476b, 38a-488a and 38a-489; and (3) the relative costs and benefits of providing effective mental health care coverage to employees and their families. On or before January 1, 2006, and annually thereafter, the Healthcare Advocate shall report, in accordance with the provisions of section 11-4a, on the implementation of this subsection to the joint

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standing committees of the General Assembly having cognizance of matters relating to public health and insurance.”

OHA takes this duty very seriously and in the last year successfully advocated for significant legislative changes to the utilization review statutes to improve access to mental health and substance use services for individuals, including those enrolled in plans sold by Access Health CT or enrolled in other commercial plans. OHA's advocacy in this area is based on our extensive experience in advocating for consumers with complex behavioral health needs and our success in overturning denials of care in state-regulated and solely federally-regulated plans.

OHA also worked with advocates in the state to support the establishment of a behavioral health task force and the establishment of an effective behavioral health system for children under P.A. 13-178.

OHA continues to partner with the [Parity Implementation Coalition](#), PIC, a national advocacy coalition, to ensure that the promise of the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is fully realized for all of Connecticut's residents, including those who are covered by health plans, self-funded plans, that are regulated by the federal government. OHA submitted public comments with the PIC and multiple stakeholder organizations in Connecticut to the Connecticut Insurance Department (CID) to suggest possible methods to check for MHPAEA compliance by Connecticut commercial plans and to make such compliance checks transparent. OHA is working with CID to share data that will allow CID to have a fuller picture of complaints on mental health and substance use services in order to guarantee MHPAEA compliance in state-regulated or commercial insurance plans.

At the request of Sen. Richard Blumenthal, OHA attended a November 7, 2013 hearing of the Senate Judiciary Subcommittee on Oversight, Federal Rights, and Agency Action titled, “Justice Denied: Rules Delayed on Mental Health and Auto Safety,” with one of our clients, Cathy Morelli, who testified about her family's difficulties in obtaining coverage for extensive treatment. The hearing, originally intended to speed up action on a final rule on MHPAEA, highlighted access to care issues faced by many individuals round the country.



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A final rule on MHPAEA was issued on November 8, 2013. OHA will continue to work with PIC and advocacy organizations to ensure that consumers understand their rights under MHPAEA and that the final MHPAEA rule is fairly enforced.

Consistent with our mandate to ensure communication concerning best practices in mental health treatment and recovery, OHA received an \$85,000 grant from the Connecticut Health Foundation to conduct an objective study of the effectiveness of the pay-for-performance strategies of the Connecticut Behavioral Health Partnership (CTBHP) to determine whether such strategies, if effective, might be used to improve treatment and recovery models in private health plan models and/or be used more broadly within the CTBHP or elsewhere.

State Innovation Model Initiative (SIM)

In 2013, the Healthcare Advocate assumed direction of Connecticut's State Innovation Model (SIM) Model Design grant under the leadership of Lt. Governor Nancy Wyman. The SIM is an initiative of the federal Centers for Medicare and Medicaid Innovation (CMMI), created by the Affordable Care Act, with a charge to participating states to design a model for healthcare delivery supported by value-based payment methodologies tied to the totality of care delivered to at least 80% of our population within five years. Moreover, the Innovation Plan must promote the Triple Aim for everyone in Connecticut: better health while eliminating health disparities, improved healthcare quality and experience, and reduction of growth in healthcare costs.

The result of the model design grant process was the [Connecticut Healthcare Innovation Plan](#). Connecticut's Innovation Plan is the product of a shared vision of a broad range of stakeholders to establish primary care as the foundation of care delivery that is consumer and family centered, team based, evidence driven and coordinated, and in which value is rewarded over volume. We envision a healthcare system rooted in primary care and prevention, integrated with community resources, and truly accessible to our residents.

The Plan is the product of a model design process embracing broad stakeholder input and alignment. We conducted more than 25 consumer focus groups, an extensive survey comprising almost 800 individuals, and more than 45 multi-stakeholder meetings including public and commercial payers, healthcare providers, employer purchasers, consumer and health equity advocates, and public agencies. These forums included wide-ranging discussions of our current healthcare system and barriers to community health improvement.

The SIM offers Connecticut a unique opportunity to transform healthcare. Yet the process is just beginning. A project management office (PMO) will be housed in OHA to continue SIM activities, including the build out of taskforces and councils on quality, practice transformation, workforce, health information technology, and equity and access. A steering committee, composed of providers, consumers, consumer advocates, state agencies, employer and payers will continue to direct the initiative. The Consumer Advisory Board and the

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Healthcare Cabinet continue to advise the steering committee on key consumer issues such as the potential for under-service in value-based payment designs. And SIM project management staff will continue to ensure legislative and stakeholder participation through regular meetings with the Consumer Advisory Board, the Council on Medical Assistance Program Oversight and its complex care committee and regular meetings with legislative leaders.

Office of the Healthcare Advocate Biennial Budget MCO39400

Position Summary Account	Actual FY 13	Original Appropriation FY 14	Original Appropriation FY 15
Permanent Full-Time - IF	18	17	17

Budget Summary Account	Actual FY 13	Original Appropriation FY 14	Original Appropriation FY 15
Personal Services	1,087,580	1,293,734	1,339,621
Other Expenses	156,485	374,985	326,267
Equipment	6,700	0	5,000
Fringe Benefits	775,139	910309	947,599
Indirect Overhead	19,211	26056	27,229
Nonfunctional - Change to Accruals	0	0	12,157
Agency Total - Insurance Fund	2,045,115	2,605,084	2,657,873

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OHA STAFF 2013

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Vanessa Wimberly

Jill Hall, RN, BS

Valerie Wyzykowski, RN, BSN

STAFF NOTES:

*Helen Sullivan resigned in December 2013.

**Candice Kohn returned as a temporary worker retiree in late 2012.

***Ifeoma Nwankwo left OHA for a permanent position at DSS.

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